STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: May 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000029300

[redacted]

Dear [redacted]

On April 30, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 8, 2017 eligibility determination notice and January 11, 2018 disenrollment notice.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of NY State of Health.

If you have questions about your Decision, you can contact us by:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification number and the Account ID at the top of this notice.

Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

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DEPARTMENT OF HEALTH
P.O. Box 11729
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Decision

Decision Date: May 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000029300

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NY State of Health (NYSOH) properly determine that you were no longer eligible for advance payments of the premium tax credit (APTC), effective January 1, 2018?
>
> Did NYSOH properly determine that your enrollment in your qualified health plan ended effective January 31, 2018?

Procedural History

On November 16, 2017, you submitted an application for financial assistance with health insurance.

On November 17, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to $366.00 in APTC for a limited time, effective January 1, 2018. You were directed to provide proof of income by February 14, 2018.

Also on November 17, 2017, NYSOH issued a plan enrollment notice stating that you were enrolled in a qualified health plan with a monthly premium responsibility of $200.03, after APTC in the amount of $366.00 was applied, effective January 1, 2018.

On December 6, 2017, the November 17, 2017 and November 18, 2017 notices were returned to NYSOH as undeliverable.

On December 7, 2017, an application was run on your behalf.

On December 8, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan at full cost, effective January 1, 2018. The notice stated that you were no longer eligible for APTC because mailings were returned to the Marketplace as undeliverable.

Also on December 8, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a full cost qualified health plan effective January 1, 2018.

On January 10, 2018, income information in your NYSOH account was updated.

On January 11, 2018, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal data sources. You were directed to provide proof of household income by January 25, 2018.

Also on January 11, 2018, you submitted income documentation.

Also on January 11, 2018, NYSOH issued a discontinuance notice stating that, effective February 1, 2018, you were no longer eligible for health insurance through NYSOH because NYSOH sent you notices about your eligibility and coverage that were returned to the Marketplace as undeliverable.

Also on January 11, 2018, NYSOH issued a disenrollment notice indicating that coverage in your qualified health plan would end effective January 31, 2018.

Also on January 11, 2018, your documentation was verified as sufficient proof of income and an application was run on your behalf.

On January 12, 2018, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective January 1, 2018.

On January 13, 2018, NYSOH issued a plan enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective February 1, 2018.

On February 23, 2018, you contacted the NYSOH Account Review Unit and appealed the date you were disenrolled from your qualified health plan, requesting the disenrollment be made effective January 1, 2018.

On April 30, 2018, you had a telephone hearing with a Hearing Officer from the NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the proceeding.

Findings of Fact

A review of the record supports the following findings of fact:

1) Your NYSOH account indicates that you were enrolled in a qualified health plan through NYSOH and that your coverage was effective as of January 1, 2018.

2) Your NYSOH account indicates that the only address listed in your account is [redacted] You testified that this is correct.

3) You testified that you had issues receiving mail at your address due to inspections by the USPS Post Master, and that the issues were resolved in March 2018.

4) You testified that you were traveling [redacted] from [redacted] to [redacted].

5) You testified that you paid premiums to your health plan for the months you had coverage. You testified that you paid the full premium for January 2018, because your account was set up with automatic payment.

6) You testified that you were not aware that you no longer had a tax credit until your qualified health plan charged you the full premium amount for January 2018.

7) Your NYSOH account indicates that you updated your application on January 10, 2018, and were directed to submit proof of income.

8) Your NYSOH account indicates that you submitted income documentation on January 11, 2018, and it was verified the same day.

9) Based on your income documentation, you were found eligible for Medicaid effective January 1, 2018.

10) You testified that you are seeking an earlier disenrollment date because you paid a full premium for a qualified health plan in January 2018 and did not use it.

11) You testified that based on the advice of your health plan, you did not use your insurance through your qualified health plan during the month of January 2018.

12) Your NYSOH account indicates that you modified your preferences in your NYSOH account on January 10, 2018 in order to receive alerts electronically.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Advance Payments of Premium Tax Credit

APTC are generally available to a person who is eligible to enroll in a qualified health plan and (1) expects to have a household income between 138% and 400% of the applicable federal poverty level (FPL), (2) expects to file a tax return and claim a personal exemption deduction for a person who meets the eligibility requirements to enroll in a qualified health plan, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45 CFR § 155.305(f), 26 CFR § 1.36B-2, 42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)).

Eligibility - State Residency

To be eligible for enrollment in a qualified health plan (QHP) and to receive an advance premium tax credit (APTC) through NYSOH, an applicant must be a resident of New York State (45 CFR § 155.305(a)(3), (f)(1)(ii)(A).

An individual who is age 21 or older, who is not living in an institution and able to indicate intent, is a resident of the Exchange service area in which: (1) they live or intend to reside, even without a fixed address; or (2) has entered the service area with a job commitment or is seeking employment. (45 CFR § 155.305(a)(3)(i)).

Termination of a Qualified Health Plan

NYSOH must permit an enrollee to terminate his or her coverage with a qualified health plan coverage, with appropriate notice to the NYSOH or qualified health plan (45 CFR § 155.430(b)(1)(i)).

If an enrollee is newly eligible for Medicaid, the last day of coverage for the qualified health plan is the day before the Medicaid coverage begins (45 CFR § 155.430(d)(2)(iv)).

For enrollee-initiated terminations, the last day of coverage is either:

1) The termination date specified by the enrollee, if the enrollee provides reasonable notice (at least 14 days before the requested termination date);

2) Fourteen days after the enrollee requests the termination, if they do not provide reasonable notice; or

3) On a date on or after the date the enrollee requests the termination, if the enrollee's qualified health plan issuer and the enrollee agree to such a date

(45 CFR § 155.430(d)(2)(i)-(iii)).

NYSOH must permit an enrollee to retroactively terminate or cancel their enrollment in a qualified health plan if:

1) The enrollee demonstrates that they attempted to terminate their coverage and experienced a technical error that did not allow the coverage to be terminated, and requests retroactive termination within 60 days after they discovered the technical error.

2) The enrollment in the qualified health plan was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of NYSOH or HHS, its instrumentalities, or a non-NYSOH entity providing enrollment assistance or conducting enrollment activities. Such enrollee must request cancellation within 60 days of discovering the unintentional, inadvertent, or erroneous enrollment.

3) The enrollee was enrolled in a qualified health plan without their knowledge or consent by any third party, including third parties who have no connection with the Exchange, and requests cancellation within 60 days of discovering of the enrollment.

(45 CFR § 155.430(b)(2)(iv)(A-C)).

NYSOH permits a qualified health plan to terminate an individual's coverage if (1) the enrollee is no longer eligible for coverage or (2) non-payment of the premiums by the enrollee (45 CFR § 155.430(b)(2)(i)-(ii)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your eligibility for APTC ended effective November 30, 2017.

For an applicant to remain eligible for enrollment in a qualified health plan through NYSOH with the application of APTC, they must meet both the financial and non-financial requirements. One of the non-financial requirements is that the applicant must be a New York State Resident.

According to your NYSOH account, on November 17, 2017 and November 18, 2017, NYSOH issued notices that was returned to NYSOH as undeliverable on December 6, 2017.

As a result, you were subsequently determined eligible for to purchase a qualified health plan at full cost, because NYSOH received mail addressed to you that was undeliverable. As such, the system assumed that you no longer met the state residency requirement for enrollment in a qualified health plan with the application of APTC. Therefore, on December 8, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan at full cost, effective January 1, 2018. Also on December 8, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a full cost qualified health plan effective January 1, 2018.

However, a review of the record reflects that these were the only two notices returned as undeliverable, despite several other notices being successfully sent to the exact same address. You testified, and the record reflects, that your address is [redacted]

Based on the credible evidence of the record, since the November 17, 2017 and November 18, 2017 notices were the only two notices returned as undeliverable to NYSOH despite other notices being sent to the same mailing address, it is reasonable to conclude that these notices were returned as undeliverable through no fault of your own, and was the result of an error of the United State Postal Service. As a result, it is reasonable to conclude that your eligibility to purchase a qualified health plan at full cost and the termination of your APTC was in error because you continued to meet the state residency requirement.

Therefore, the December 8, 2017 eligibility determination notice finding you eligible to purchase a qualified health plan at full cost, effective January 1, 2018, is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your eligibility for APTC of up to $366.00 per month for the month of January 2018.

The second issue under review is whether NYSOH properly determined that your enrollment in your qualified health plan ended effective January 31, 2018.

On November 17, 2017, NYSOH issued a plan enrollment notice, based on your plan selection on November 16, 2017, confirming your enrollment in a qualified health plan effective January 1, 2018. On December 8, 2017, NYSOH issued a

plan enrollment notice confirming your enrollment in the same qualified health plan.

You testified that you are seeking retroactive disenrollment from your qualified health plan effective January 1, 2018.

NYSOH must permit an enrollee to be retroactively disenroll from their qualified health plan if the enrollee demonstrates that there was a technical error that should have allowed them to terminate coverage earlier, or if their enrollment in the plan was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of NYSOH, its instrumentalities, or a non-NYSOH entity providing enrollment assistance or conducting enrollment activities, or the enrollee was enrolled into a qualified health plan without their knowledge or consent by a third party.

There is no indication in the record that your enrollment in a qualified health plan as confirmed in the November 17, 2017 plan enrollment notice was unintentional, inadvertent, or erroneous, nor was your enrollment in a qualified health plan the result of the error or misconduct of an officer, employee, or agent of NYSOH, its instrumentalities, or a non-NYSOH entity providing enrollment assistance or conducting enrollment activities. Furthermore, there is no indication that your enrollment in a qualified health plan as confirmed in the November 18, 2017 enrollment confirmation notice was without your knowledge or consent.

Therefore, there is no basis to find that NYSOH must permit you to retroactively terminate or cancel your enrollment in a qualified health plan.

Therefore, NYSOH properly determined that your plan terminated as of January 31, 2018. NYSOH's January 11, 2018 disenrollment notice is AFFIRMED insofar as it terminated your qualified health plan as of January 31, 2018.

Decision

The December 8, 2018 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your eligibility for APTC of up to $366.00 per month for the month of January 2018.

The January 11, 2018 disenrollment notice is AFFIRMED.

Effective Date of this Decision: May 10, 2018

How this Decision Affects Your Eligibility

Your eligibility for APTC should not have been terminated as of January 1, 2018.

Your case is being sent back to NYSOH to reinstate your eligibility for APTC for the month of January 2018.

This decision does not change your disenrollment date. Your enrollment in your qualified health plan properly ended as of January 31, 2018.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to the Federal Marketplace or bring a lawsuit under New York Civil Practice Law and Rules, Article 78.

You may bring a lawsuit on any Appeals Unit decision in New York State court in accordance with Article 78 of the New York Civil Practice Law and Rules. This must be done within four months of the Decision Date, which appears on the first page of this Decision.

Additionally, Appeals Unit decisions on issues involving eligibility for qualified health plans, advance premium tax credits, and cost-sharing reductions may be appealed to the Federal Marketplace. This must be done within 30 days of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c)).

If you have questions about appealing to the Federal Marketplace, you can contact them in any of the following ways:

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:

  Health Insurance Marketplace
  Attn: Appeals
  465 Industrial Blvd.
  London, KY 40750-0061

- By fax: 1-877-369-0129

If you wish to be represented by an attorney in bringing an outside appeal and do not know how to go about getting one, you may contact legal resources available to you. You may, for example, contact the local County Bar Association, Legal Aid, or Legal Services.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

If You Have Questions about this Decision (Customer Service Resources):

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The December 8, 2018 eligibility determination notice is RESCINDED.

Your eligibility for APTC should not have been terminated as of January 1, 2018.

Your case is RETURNED to NYSOH to reinstate your eligibility for APTC of up to $366.00 per month for the month of January 2018.

The January 11, 2018 disenrollment notice is AFFIRMED.

This decision does not change your disenrollment date. Your enrollment in your qualified health plan properly ended as of January 31, 2018.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

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Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली (Nepali)

यो एउटा महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई नि:शुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

اردو (Urdu)

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

אידיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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